Birth Mother Application

Today's Date _____

Full Name _____ Est. Delivery Date_____

Address _____

City _____ State _____ Zip _____

E-Mail Address _____ Social Media "Name" _____

Phone # _____Is it ok to text to this phone? Y/N _____

Best time to reach you _____ Can we leave identifying message on phone? Y/N _____

Emergency contact/Relationship: _____ Phone # _____

Age _____ DOB _____ Place of Birth _____

Gender of Baby (if known) _____ Have you had any Prenatal Care? Y/N_____

When did you begin prenatal care? _____ Do you have Medical Insurance? Y/N_____

Dr. /Clinic Name & Phone # _____

If you found us online, what search engine did you use and what words did you type in to find us?

_____

Are you a U.S. Citizen? Y/N _____ If No, do you have a green card? _____

Your Race/Ethnic Background: African American _____ Caucasian _____ Hispanic _____

Asian _____ *Native American _____Other _____

***Native American-Indian Tribal Membership*: *Are you a registered member of any *Native American Indian tribe? Y/N _____ If Yes, please indicate the tribe name & location _____ and your registration or Identification number _____. List all family members with tribal affiliation._____**

Height _____ Eye Color _____ Complexion _____ Hair Color _____

Type of hair _____ Bone Structure _____ Left or Right handed _____

Marital Status: Married _____ Divorced _____ Separated_____

Single_____

Acadia Adoption Center, LLC
PO Box 623, Naples, ME 04055

T: 207-467-8110 F: 207-514-9400
www.BirthMothersJourney.com info@AcadiaAdoptionCenter.com

Birth Mother Application, Cont.

Occupation/Employer: _____

My reason(s) for making an adoption plan: _____

_____

I am open to my unborn child being placed with: Traditional Couple _____ Single Parent _____
Same Sex Couple_____ Any_____ Does age of the adopting parents matter to you? Y/N_____

Have you traveled out of State or outside of the United States in the past 12 Months?
Y/N_____ If Yes, please indicate where _____

Birth Father Information

Does the birth father know about this pregnancy? Y/N_____

Does the birth father support an adoption plan? Y/N_____

What is your relationship with the birth father? _____

_____

Birth father's Race/Ethnic Background: African American _____ Caucasian _____
Hispanic _____ Asian _____ *Native American _____ Other_____

***Native American-Indian Tribal Membership*: Are you a registered member of any *Native American Indian tribe? Y/N _____ If Yes, please indicate the tribe name & location _____ and your registration or Identification number _____. List all family members with tribal affiliation._____**

RELEASE OF LEGAL, MEDICAL, SOCIAL, AND MENTAL HEALTH RECORDS

I hereby authorize the release of all information and records in my possession or under my control or in the possession or under the control of any of my agents, including the obstetrician, pediatrician, physician, medical facility, counselor, psychiatrist, psychologist, social worker, or adoption agency attorney, or any other professional who may have access to such records to **Acadia Adoption Center, LLC, 132 Main Street, Suite #201, Bridgton ME 04009, (877-723-6789, 207-467-8110)** a duly authorized, licensed adoption agency.

This authorization is meant to include any and all confidential and/or privileged material you or any person under your control or of your employer or any person under his/her control may have, and including but not limited to written notes, assessments, correspondence, reports, evaluations, diagnoses, case plans, notes of meetings, telephone records, test results, and any other documents relative to me, whether kept in writing or electronically recorded by video, tape, computer disk, or maintained in computerized form of any kind. This is meant to waive any confidentiality or privilege, which may attach to such information.

I understand that **Acadia Adoption Center, LLC,** will be ***notified immediately*** if I disclose that I am no longer making an adoption plan, no longer working with this agency, or if I disclose that I am working with any other adoption agency/entity.

This authorization shall become effective immediately and shall remain in effect as long as necessary for **Acadia Adoption Center, LLC**, to fulfill the obligations required by the activities undertaken, but no longer than one (1) year from the date of signing.

DOB: _____ **SSN:** _____

_____

Name (printed)

_____

Signature of Individual or Legal Representative

Authorization to DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: _____

Date of Birth: _____ Social Security No: _____

Address: _____

City: _____ State: _____ Zip: _____

I _____ authorize my health care provider(s) to
(Patient)
discuss and release information related to my medical history and current pregnancy with representatives of **Acadia Adoption Center, LLC,** a licensed adoption agency, for the purposes of making an adoption plan.

I understand that the medical records may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral or treatment for alcohol and drug abuse (as permitted by 42 CFR Part 2).

This information may be disclosed to and used by the following person(s) or organization,

- Attorney(s) or agency for adoptive parent(s)
- Adoptive parent(s)
- Court in connection with adoption, as necessary
- Interstate Compact on the Placement of Children, as necessary
- Other_____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Acadia Adoption Center, LLC. Unless otherwise revoked, this authorization will expire one year from the signature date.

I understand that authorizing the disclosure of this health information is voluntary. I also understand that my refusal to sign may affect my ability to move forward with my adoption plan.

By signing this Authorization, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed authorization. A photo static copy of this authorization shall serve in its stead.

_____ _____

Signature of Individual or Legal Representative **Date**

Relationship of Representative: _____